BALANZE PHYSICAL THERAPY & WELLNESS
479 TURNPIKE STREET #7
SOUTH EASTON, MA 02375

PATIENT NAME:_____

1. What would you say is the pain rating for your current condition using a scale of 0 – 10? (0=no pain, 10=worst pain imaginable)

_____

2. Do you now or have you ever had the following?

	YES	NO	EXPLAIN
STROKE			
HEART DISEASE/MURMUR			
HIGH BLOOD PRESSURE			
ASTHMA			
DIABETES			
EPILEPSY/FAINTING			
IMPAIRMENT VISION			
IMPAIRMENT HEARING			
OSTEOPOROSIS			
ALLERGIES			
DRUG USE			
TOBACCO USE			

MEDICATIONS	DOSAGE

PLEASE COMPLETE THE OTHER SIDE

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Orthopaedic History – Please give dates & treatments received:

1. Have you ever sprained, strained, dislocated or fractured the following:
   Neck/Head (including concussion)
   _____
2. Trunk (ribs, vertebrae, sternum)
   _____
3. Low Back (vertebrae, discs, nerves)
   _____
4. Upper Extremity (shoulder, elbow, wrist, arm)
   _____
5. Lower Extremity (hip, leg, knee, ankle, foot)
   _____
6. Please list any surgeries that you have had and their dates:
   _____
   _____
7. Women: Are you pregnant? yes _____ no _____
8. Have you ever had PT in the past?
   _____
9. If so, when? where?
   _____

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur, I will notify my PT immediately

Signature_____date:_____

PLEASE COMPLETE THE OTHER SIDE